Eye Physicians of the East Bay

NEW PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________ M.I. __________

Address: ________________________________ City: ________________ Zip: __________

☐ Male Date of Birth: _____/_____/_____ Age: _____

☐ Female

☐ Non-Binary

Cell Phone ( ) ________________ Work/Home ( ) ________________________

*May we speak to anyone at your home or leave a message on your machine. Yes or No

Ethnic Origin :_____________________ Driver's License #: ________________________

Marital Status

☐ Married Occupation: ____________________ Employer: ______________________

☐ Widowed How were you referred to our office? ________________________________

☐ Divorced

☐ Single Are you under the care of an Optometrist? ____________________________

RESPONSIBLE PARTY INFORMATION (If different than above)

Last Name: ______________________ First Name: ______________________ M.I. __________

Address: ________________________________ City: ________________ Zip: __________

☐ Male Date of Birth: _____/_____/_____ Age: _____ SS #: _____-_____-_____

☐ Female

Cell Phone ( ) ________________ Work/Home ( ) ________________________

Relationship to Patient: ____________________

Primary Insurance

HMO PPO Medicare Medi-cal Private Medical Group: ____________

Name of Insurance Company: ________________________________ Policy# ________________

Address: ____ Group# ________________

City: ___________________________ State: ________ Zip: ________

Secondary Insurance

HMO PPO Medicare Medi-cal Private Medical Group: ____________

Name of Insurance Company: ________________________________ Policy# ________________

Address: ____ Group# ________________

City: ___________________________ State: ________ Zip: ________

Vision Insurance

Name of Insurance Company: ________________________________ Policy# ________________

Address: ____

City: ___________________________ State: ________ Zip: ________

Patient Name: ___________________________
MRN: __________________

Permission for Electronic Communication
Eye Physicians of the East Bay ("EBEB")

1. **Text Messaging**

EPEB would like to contact you via text messaging using your personal phone regarding appointment reminders, notices, and promotions. Some limited personal information may be included however no medical or test results will be specified. Initial below if you wish to be contacted via text messaging or not.

________ (Initial) **Yes, I want** EPEB to use my cell phone listed below to send text messages for the purposes of appointment reminders.

Cell/Text Message Number: (   )

Please contact our office immediately with any change in your phone number.

– OR –

________ (Initial) **No, I do NOT want** EPEB to use my cell phone to send text messages for the purposes of appointment reminders.

2. **Email/Patient Portal**

EPEB offers patients access to their health record through our Patient Portal. Through the Patient Portal you may request current prescription refills, view laboratory results, request appointments, review medication lists, problems lists, immunization records and allergies. Communication sent between yourself and EPEB staff through the Patient Portal will become a part of your patient records. The Patient Portal is NOT intended to provide internet- based diagnostic medical services.

EPEB additionally uses email to deliver HIPAA secure patient satisfaction surveys. Feedback from these surveys is used to improve upon our services, and is anonymous (NOT a part of your record).

________ (Initial) **Yes, I want** EPEB to use my email address listed below to create a Patient Portal account for the purposes of allowing me access to the information listed under Email/Patient Portal. I additionally consent to the use of my email address to receive patient satisfaction surveys.

Email Address - Please print CLEARLY, this information is used to set up your account:

Please contact our office immediately with any changes to your email address.

– OR –

________ (Initial) **No, I do NOT want** EPEB to use my email address to create a Patient Portal account for the purposes of allowing me access to the information listed under Email/Patient Portal. I do not wish to receive patient satisfaction surveys via email.

Print Name:	Date of Birth:

_____________________________________ Signature

_____________________ Date

PATIENT INFORMATION

Assignment of Benefits I authorize Eye Physicians of the East Bay to bill my insurance for all services rendered in order to collect on any payments issued on my behalf. Furthermore, I agree to have any medical records copied and sent to my insurance company to facilitate claim payment and processing. This assignment may be copied and used the same as an original document. By initialing below, I acknowledge that all information is true and that I am compliant with the assignment of benefits. __________ **(Initial)**

HIPAA-Patient Privacy Act I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by initialing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); obtaining payment from third party payers (e.g. my insurance company). I further acknowledge that a copy of the current notice will be made available to me upon request, and I will be offered a copy of any amended notice of Privacy Practices at each appointment.__________**(Initial)**

Financial Policy We would like to thank you for choosing Eye Physicians of the East Bay as your healthcare provider. Our office is committed to providing you with the best possible medical care. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

For our Patients with Medical Insurance We participate in most major health plans. We contract with two HMO's (Hill Physicians and Affinity Medical Group) two vision plan (Vision Service Plan (VSP) and Medical Eye Services (MES) as well as many PPO's, and government agencies including Medicare and Medicaid. Our billing department will submit claims for all covered services rendered to a patient who is member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier is paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Non-paid claims resulting from lack of patient follow up will become the patient's responsibility.

Your insurance may require you to obtain an authorization or referral from your primary care physician or the insurance company directly. This is common among the majority of HMO plans and it is the patient's responsibility to obtain prior to being seen. This is a requirement set by your insurance and we may need to reschedule your appointment if the proper documents are not obtained prior to your scheduled appointment.

Co-payments: Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and local law. Please help us in upholding the law by paying your co-payment at each visit. For your convenience we accept cash, checks or the following credit cards: Visa, MasterCard, American Express, Discover and ATM transactions. If you do not have your co-payment you will be subject to a $15.00 service fee.

Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account, after adjusting all of your insurance's responsibilities, will be billed to you.

Non-Covered Services: Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

For our Patients with No Medical Insurance: If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit. Please note, we do offer discounted fees for patients without health insurance.

Treatment of Minors: Patients under the age of eighteen should be accompanied by a parent. The parent or guardian of record with the minors chart will be responsible for payment of services. In rare cases, when a minor comes unaccompanied by a parent or guardian, the minor must have written consent from the parent of record, authorizing treatment as well as payment for services rendered.

Eye Physicians
of the East Bay
Medical Corporation
Diplomates, American Board of Ophthalmology

REFRACTION POLICY

A complete eye examination in our office includes a procedure called a refraction. This measurement lets the doctor and patient know what is the best vision that each eye is capable of and what glasses prescription, if any, would be needed to achieve that level of vision.

The fee for a refraction is always covered by routine vision-care insurances, such as VSP (Vision Service Plan) or MES (Medical Eye Services).

However, most medical insurances companies including Medicare will not cover refractions even if the patient is being seen for medical reason. Unless you are using an insurance that we know will pay for your refraction, you will be asked to pay for this service at the time of your visit. As a courtesy we will submit a bill for the refraction to your insurance company, and any payment that we might receive will be forwarded to you.

If you wish not to have the refraction performed, please check the box below so you will not be responsible for the charge.

By signing our financial policy, you are acknowledging that you are responsible for all charges not covered by your insurance.

☐ I decline to have the refraction performed during today's visit.

☐ I would like to have a refraction performed today and understand that the $60 fee for this service is due and payable today.

________________ ____

Date Signature of Patient or Person Acting on Patient's Behalf

I have read and understand the financial policy, HIPAA-Patient Privacy Act, and Refraction Policy of Eye Physicians of the East Bay and assume responsibility for payment of all services and materials.

Signature____Date_____________________________________

80 Grand Ave., Suite 700, Oakland, CA 94612
Phone 510-893-4318
Fax 510-893-1108

3685 Mt. Diablo Blvd., Suite 100, Lafayette, CA 94549
Phone 925-283-8400
Fax 925-283-8500

Eye Physicians of the East Bay

MEDICAL HISTORY QUESTIONNAIRE

Last name, First name: ______________________________ Birthdate: __________ Today's Date: __________

Last Eye Exam: __________ Physician: ______________________________ Last Medical Exam: __________

Do you wear: Glasses? ☐ Age of current pair? __________ Contacts? ☐ Age of current pair? __________

Tell us about any unusual visual needs you may have for your work or hobbies: ______________________________
Are you interested in finding out more about Contact Lenses or Laser Vision Correction? ______________________________

Past Ocular History/Conditions/Surgeries:

Condition	Date of Onset	Treatment

List any Medications including Ocular Medications You Currently Use *(also include oral contraceptives, aspirin, over the counter medications and home remedies):*

Drug	Strength/Dose/Directions	Purpose (ie. for high blood pressure)

Do you have any allergies to medications? ☐ No ☐ Yes If yes, explain: ______________________________
Are you pregnant and or nursing? ☐ No ☐ Yes ______________________________

Past Medical History/Conditions/Surgeries:

Condition	Date of Onset	Treatment

****Please turn over to complete other side of this form****

Family History for the following conditions *(Note any family history: parents, grandparents, siblings, children, living or deceased)*:

Disease / Condition	No	Yes	?	Relationship to You

Social History (*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)*

□ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? □ No □ Yes If yes, do you have visual difficulty when driving? □ No □ Yes If yes, describe: ______________

Do you use tobacco products? □ No □ Yes If yes, type/amount/how long:

Do you drink alcohol? □ No □ Yes If yes, type/amount/how long:

Do you use illegal drugs? □ No □ Yes If yes, type/amount/how long:

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

Where were you born and raised? ____

Review of Systems: Do you currently have any problems in the following areas? (Such as)?

SYSTEM	No	Yes	If yes, please list symptoms
CONSTITUTIONAL (Fever,Weight Loss/Gain)			
INTEGUMENTARY (Skin rash)	□	□	
NEUROLOGICAL: (headaches/seizures)	□	□	
EYES (blurred, distorted, double vision, dryness, mucous discharge, redness, itching, burness, tearing, foreign body sensation, glare, styes, flashes, floaters)	□	□	
ENDOCRINE (thyroid, diabetes, fatigue)			
PSYCHIATRIC (depression, schizophrenia)	□	□	
EARS, NOSE, MOUTH, THROAT (hay fever, sinus, post nasal drip, runny nose)	□	□	
RESPIRATORY (cough, shortness of breath)	□	□	
CARDIOVASCULAR (heart pain, leg claudication)	□	□	
GASTROINTESTINAL (diarrhea, constipation, pain)	□	□	
GENITOURINARY	□	□	
(incontinence, dialysis, bladder infection)	□	□	
MUSCULOSKELETAL (joint/muscle pain)	□	□	
HEMATOLOGIC/LYMPHATIC (anemia, bleeding problems)	□	□	
ALLERGIC/IMMUNOLOGIC (lupus, active allergy)	□	□	

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